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ABSTRACT

The PRYDE program is described as a foster family-based treatment program which has treated a wide diversity of seriously disturbing child behaviors since 1981 with a 70% success rate of discharging children to less restrictive settings. Children are treated individually within separate families and local communities, thus avoiding problems associated with group residential settings. Foster parents are trained to function as highly qualified treatment agents by using a variety of teaching, motivational, and relationship-building skills. They document daily use of these skills according to an individualized treatment plan. Supervision and in-home training are conducted by a parent supervisor, who also provides 24-hour on-call services to parents. The bulk of the document consists of detailed case studies of three children ages 6, 11, and 18 which illustrate how family-based treatment can be highly individualized for children with widely differing presenting problems. (Nine figures are provided.) (JW)

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Meeting the Challenge: Treating Diverse and Difficult Problems in Therapeutic Foster Families

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Paper presented at the August, 1987 Meeting of the American Psychological Association, New York City, NY.

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The current challenge to foster family-based treatment (FFBT) programs, and the implicit or explicit models that underly each, is to extend service delivery to children with diverse and unique behavior problems. Child care institutions, residential treatment facilities, and to some extent, group homes design and implement their therapeutic regimes for relatively homogeneous populations or arrange subgroups of youths whose problems are similar. As a result, it is programmatically difficult for such environments to treat children with unusual combinations of problems. The FFBT approach would appear the logical choice among residential service alternatives to meet this challenge because it can provide an environment which is flexible and highly responsive to the individual child's unique constellation of skill and performance deficits. In addition to the overall benefits of FFBT (e.g., treatment cost, high staff to child ratio, consistency of treatment performance across staff), there are still more compelling reasons to consider treating a wide diversity of seriously-disturbing child behaviors within FFBT settings.

1. preventing increasingly restrictive treatment environments of children who, because of the severity of their behaviors, either do not clinically fit in to other treatment alternatives or have not benefited from their stay in previous programs.

2. empirically demonstrating the efficacy of FFBT programs with particularly difficult and different types of child behavior.

3. identifying and analyzing program failures so that the existing program limitations can be defined and modified to increase the probability of success with yet more children.

The PRYDE program represents a viable alternative for extremely difficult-to-treat children who display seriously divergent problems. Because children are treated individually within the context of separate families and local communities, PRYDE avoids some of the limitations inherent in treating children in group residential settings. In PRYDE's family-based treatment program, parents are trained to function as highly-qualified treatment agents by using a variety of teaching, motivational, and relationship-building skills. PRYDE parents are required to document their daily use of these skills according to an individualized treatment plan developed by a

professional staff. Supervision and in-home training are conducted during frequent visits to PRYDE homes by the parent supervisor, who also provides 24 hour on-call services to parents.

Since its inception in 1981, PRYDE has served over 275 children from 3 to 18 years of age with a wide variety of presenting problems and has a 70% success rate of discharging children to less restrictive settings. Child demographics are displayed in Figures 1 through 6, which show data on gender, race, age at first out-of-home placement and placement in PRYDE, primary educational classification, prior placements, and problem behaviors at referral, respectively. It is worth noting that the average number of prior placements across children treated by PRYDE is 3.1, with a range of 0 to 20 placements. A fact which underscores the diversity of referred children's problem behaviors is that the mean number of problems reported is 6.3 behaviors and a range of 0 to 17. To illustrate how family-based treatment can be highly individualized for each child, three PRYDE children with very different presenting problems will be discussed.

CASE 1

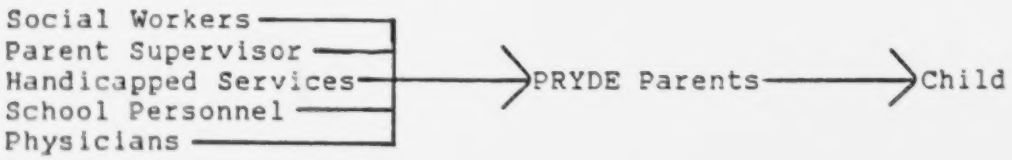
Wendy is a 6 year-old caucasian female who is multiply-diagnosed as suffering from Spastic Cerebral Palsy, profound mental retardation, epileptic seizures, near total blindness due to marked optical atrophy, and microcephaly. These physical and intellectual disabilities are the primary result of a prenatal cytomegaloviral infection, a medical entity which is relatively rare in the U.S. population. The average incidence of CMV infection is 1% of all live births, and it is estimated that only 5 to 10 percent of those infected have the more virulent form which leads to such extensive impairment.

Wendy was placed in an emergency shelter foster home when she was 2.7 years old. She had been removed from her natural family because of severe neglect; her biological mother routinely feed her only one time per day because of the difficulty and time involved in getting Wendy to keep food in her mouth and swallow. Necessary medical and physical therapy appointments were not kept and Wendy's seizure disorder remained uncontrolled. Her biological father left the home soon after Wendy's birth and his whereabouts were still unknown at the time Wendy was removed. Her mother was charged with neglect and all parental rights were subsequently terminated. The foster couple who cared for Wendy during the next 2 years had become extremely frustrated with her developmental progress and dissatisfied with the degree of technical support available to them. The DHS Caseworker involved with this family referred Wendy and her foster family to PRYDE to prevent Wendy from being moved to the only other viable placement option; an overcrowded state MR/DD residential facility. After

receiving training to be certified as PRYDE parents, Wendy was "placed" back with them through PRYDE on December 1, 1986

When PRYDE began working with this family, Wendy's average level of developmental functioning across all areas was 1.5 months. She did not vocalize other than loud screams and crying, did not initiate or maintain a sitting posture, ate only pureed baby foods and drank fluids from a bottle, did not exhibited a poor swallowing reflex which caused frequent gagging and vomiting of food, enagged in frequent self-abusive and self-stimulatory behaviors (e.g., finger biting which resulting in bleeding and scarring, head banging, abrading skin on her feet and chin by repeatedly rubbing across textured surfaces, mouthing objects), slept only a few hours during the night, and became very irritable whenever touched or held. Physically, she was markedly underweight, experiencing daily seizures, had frequent ear infections, and suffered from nearly continous respiratory infections.

A major feature of Wendy's treatment regimen has been the development, integration, and coordination of many clinical consultations and specialized diagnositic services. In order to obtain needed collateral treatment services for Wendy, it was imperative that her PRYDE parents be well-trained in the management of available community resources, child advocacy, and consumption of professional services. It was due to this in-home skill teaching that the PRYDE parents were able to utilize information and recommendations from child care professionals to enhance their direct treatment with Wendy. The following diagram exemplifies the flow of services to this child within the PRYDE model:



Because of the extent of Wendy's physical and intellectual limitations, it was necessary to modify the typical PRYDE motivation system. Instead of consequating the child's behavior via the motivation system, those treatment skills of the PRYDE parents which corresponded to the child's targeted behaviors were specified on the point sheet (See Figure 7). The advantages to the PRYDE parents of such a change were threefold. First, their point sheet acted to cue or prompt them to engage in the numerous therapeutic activities and procedures across the day, many of which were scheduled across specific times of the day. Second, they received feedback on their performance each day when they calculated their net point totals. Third, they could earn a small daily allowance based on their accumulated points and spend this money on anything they wished. In addition to completing their point sheet and documentation of parenting skills on a daily

basis, the PRYDE parents collected and maintained detailed data on Wendy's performance during training trials and assisted in graphical analyses of these data to guide treatment planning and implementation (See Figure 8).

Wendy's current levels of functioning, assessed by standardized measures of infant development, are at 4 months for expressive language, 3 months for fine motor skills, and 2 months for gross motor skills. She eats solid food, drinks from a cup, produces monosyllabic sounds in response to verbal stimuli, sleeps 6 to 8 hours per night without screaming or crying, expresses pleasure when she is held or touched, and has shown a large decrease in her rate of self-abusive behaviors (See Figure 9). Wendy rides a schoolbus to attend a special education class for MR/DD children twice per week, and will be attending school 5 days per week this Fall. Her PRYDE parents report that they are pleased with Wendy's progress, the efficacy of the skills they have learned, and with the technical and emotional support that PRYDE provides. Wendy's teachers and DHS Caseworker also report noted improvement in the PRYDE parents, stating that they seem quite confident now and are more optimistic about helping Wendy function in spite of her disabilities.

CASE 2

David is an 18 year old black male who was referred to PRYDE at the age of 14. He is the third of four siblings and was born four-weeks prematurely. At age two, the couch he was sleeping on while at home caught on fire and resulted in severe scarring on his face, scalp, and one arm. Plastic surgeons advised that attempts at cosmetic improvement should not be considered until David was at least age 16. Soon after this incident, David's father left home and his unemployed mother developed a chronic alcohol addition. David was neglected by his mother and rejected by other adults and children in his neighborhood. His first documented contact with child protective services occurred when he was six and his mother was found intoxicated. At age eight, he was again removed from his mother's custody because of alcohol intoxication and neglect, but again was returned home. At age ten he was placed in an emergency shelter after apparently burning down a vacant apartment building. At that time, it was reported that David had been noncompliant and aggressive for several years, had many attempts at running away from his home, refused to attend school, destroyed property and shoplifted, and exhibited nocturnal enuresis.

During his time at this shelter, David was evaluated and diagnosed as physically handicapped with a hearing loss, intellectually functioning in the mild mental retardation range, and was emotionally disturbed. Following a two-month inpatient psychiatric evaluation, David was placed in a residential treatment program for three years. During this time, he received diagnoses of: anxiety reaction of childhood with psychotic

behavior, secondary to possible mixed organic brain syndrome; chronic depression; conduct disorder of childhood, undersocialized, aggressive type; borderline intelligence, with full scales IQ scores ranging from 64 to 76; school and family dysfunction. When referred to PRYDE, his behavior was described as psychotic, erratic, and bizarre. He talked to himself in different voices, "became" objects, and always wore multiple layers of clothing to cover his scars. David slept in all of his daytime clothing as well, which consisted of full-length pants and shirts, gloves, a hat, and at least one coat regardless of the season.

Of the 37 problem behaviors observed and targeted for behavioral intervention following David's placement with his PRYDE family, the following is a sample listing by behavior categories:

Inappropriate verbal behavior -- talking to himself in different voices in public; reporting that he heard voices of other people in his head; communicating by nonvocal gestures only; aggressive and threatening speech; expressing rigid and immutable beliefs contrary to physical evidence; stating that he was an inanimate object when stressed.

Inappropriate social interactions -- destruction of property; physical aggression towards children in the absence of adults; poor social skills displayed with peers; avoidance of leisure or recreational activities; responding aggressively when receiving criticism or negative feedback; expressing sexual interest in very young girls; frequently interupting the interactions of others to gain attention.

Inappropriate emotional responses -- flat affect; devoid of humor; refusal to allow others to touch him; difficulty differentiating between reality and fantasy; overly anxious and fearful; denial of possessing any feelings; refusal to share or give gifts to others; demanding excessively structured routines.

Inappropriate other behavior -- refusal to wear new clothing; wearing multiple layers of clothes regardless of season; refusal to spend money; frequent nightmares; self-induced vomitting after meals; expressing confusion of his own racial identity.

In treating David's unusual combination of behavior problems, various interventions and procedures were implemented by his PRYDE family in their efforts to obtain the desired behavior change. It was often the case that the logical and usual procedures used to change David's behavior were ineffective or occasionally caused an escalation of undesirable behaviors. An example of the highly-individualized treatment planning that was necessary with David is the dramatic change of a target behavior which resulted from a planned ignoring procedure used by all of his PRYDE family members. The family achieved success,

however, only after their use of skill teaching, time out, various communication techniques, intermittant reinforcement of alternative behaviors, and restriction of privileges failed to produce the desired change.

Teaching new and replacement behaviors was an essential part of David's treatment because he had previously learned to avoid or escape from many situations which routinely confronted him. The successful shaping and reinforcing of David's appropriate verbal responses was made possible by the careful monitoring of daily progress and the individual attention of his PRYDE parents. An important outcome of this shaping was David's accurate labeling of his feelings and those of others. Effective use of the motivation system allowed David's environment to strengthen his newly learned skills and to promote generalization of these skills to novel settings.

David is now in the process of successfully completing a vocational and educational program at a local community college, and has received over eight difference job offers. He has undergone two separate operations which totaled 29 hours of plastic surgery. He now appears comfortable with his appearance and no longer "hides" behind multiple layers of cholthing. One year after his discharge, David maintains contact with his PRYDE parents through telephone calls and weekend visits each month. Even though these follow-up services between David, his PRYDE parents, and Parent Supervisor are not part of a formal treatment plan, David's continuing relationship with his PRYDE family is due to their shared history of therapeutic interactions.

CASE 3

Mary is an 11.9 year-old caucasian female who was referred to PRYDE at age 11. Mary is eldest of three children; her brother is currently living in a specialized foster home and her sister is living in another PRYDE home. Mary's father is currently serving a 20-year jail term for child sexual abuse. Her mother, alledgedly a prostitute, is serving a 6 to 9 month jail term for reckless endangerment and child neglect, both related to the father's abuse charges. Evidence of serious emotional disturbance and familial disruption is also present in the extended family. Mary's maternal Grandmother and Uncle committed suicideand her maternal Aunt has nine children who are all placed outside the home.

The first contact of Mary's family with child protective services occurred when she was nearly four years old. She and her brother were removed from their parents and placed in foster homes for 15 months because of parental neglect. Four years later, all of the children were removed from their home due to a combination of neglect, physical abuse, and sexual abuse. These children were punsihed by their parents by being tied up, locked in closets, or locked in the basement for days at a time. They

were beaten with sticks and belts, and have scars which resulted from parent-inflicted burns. It was reported that all of the children were sexual abused by their father on repeated occasions. Sexual abuse also was prepetrated by a family friend who often babysat, and is now serving a 5-year jail term for this behavior. The children were apparently abused in view of each other, with adults watching and taking photographs, and were reportedly forced to participate in intercourse with animals.

At age 9.5, Mary was placed in an emergency shelter and was so diruptive while there that she was hospitalized in a program for multiply-hanicapped children. Following two months of treatment, she was placed in a residential program for seriously-disturbed children. During this time, she was interviewed by a local program that specializes in treating young sexual abuse victims, but was rejected because there were too many complicating problems which mitagated against a successful treatment outcome in this program. After 14 months, Mary was admitted to a psychiatric hospital for evaluation of a long-term placement at a local state hospital. It was at this point that PRYDE offered to treat Mary in a PRYDE home with simultaneous enrollment in the Pressley Ridge Day School. After a great deal of discussion, the involved Children and Youth Services staff placed Mary with PRYDE/Day School in December, 1986.

At the time of placement, Mary academically functioned at a kindergarten level and exhibited severe language delays as well. She displayed a wide range of intensively aggressive behaviors towards both adults and peers, including trowing objects, biting, hitting, kicking, scratching, and hair pulling. During her first 3 months, Mary had been physically restrained from hurting others on 114 occasions, which is a higher rate than for the other 115 Day School students combined. She also caused more staff injuries during this period than all of the other students combined. Her tantrum behavior often escalated to physical aggression whenever her behavior produced a negative consequence.

Because of classroom limitations governing the use of time out procedures in response to her aggressive behavior, her school adjustment was quite problematic. Based on the data that resulted from the various procedures implemented by teachers, concurrent schedules of positive teacher attention and token rewards were established on a minute to minute basis. Although labor intensive, this intervention produced a rapid and steady decrease in Mary's physical attacks on others. By the end of the school year, Mary was responding favorably to her SED class regime and was beginning to demonstrate limited academic progress. It was at this time that Mary's PRYDE family moved out of the area and she was placed with the PRYDE family which was treating her sister.

Mary's aggressive behavior at home was less frequent and severe than at school because her PRYDE parents were very

persistent in consequating her undesirable behavior with a brief time out procedure (sitting in a chair). Initially Mary's behavior at home occasioned 5 to 6 timeouts per day, but now timeouts rarely happen because she is able to respond appropriately to more temporally distant consequences such as loss of privileges. Mary now demonstrates that she has learned to respond to the instructional control of her PRYDE parents, and has begun to generalize these skills to other people.

Mary experienced a very good summer, during which she successfully completed an Easter Seals camp and won a gold medal in a Special Olympics event. She required the use of physical restraint on only one occasion this summer and that incident occurred at home. With much teaching and emotional support, Mary and her sister have started to develop a healthy sibling relationship to replace their previous roles as parent and child. Socially, her conversational skills are greatly improved, her social competency with peers is better, and she is participating in more group activites. She can now play simple games with other children and has joined a softball team. The progress Mary has made to date is modest and has been slow, but it is taking place and it is occurring within a normal family setting instead of inside a custodial state institution.

In conclusion, the children presented have very divergent behavior problems which require very different treatment approaches, and they also share at least five things in common. First, each child benefits from a high staff to client ratio within their therapeutic environments, with two or more treatment agents per child. Second, the stability and continuity of the treatment staff (i.e., PRYDE family, teachers, Parent Supervisor) remain fairly high across time. Third, continuous access to a team of highly-trained allies which advocates for a single child within his or her community, and possesses many resources at local and state levels is available. Fourth, frequent communication and a high degree of intra- and inter-treatment agent consistency across the PRYDE family and Parent Supervisor is maintained. And fifth, a treament environment which is highly flexible and able to respond promptly to the clinical needs of the individual child is present. PRYDE believes that these features are essential components of an effective treatment program alternative to the institutionalization of children who are extremely difficult to treat. Further, PRYDE maintains a strong conviction that this model of FFBT holds much promise for expanding the present limitations of treating extremely troubled children in minimally-restrictive settings.

Figure 1
Current Percentage of Male and Female PRYDE Children (N = 149)

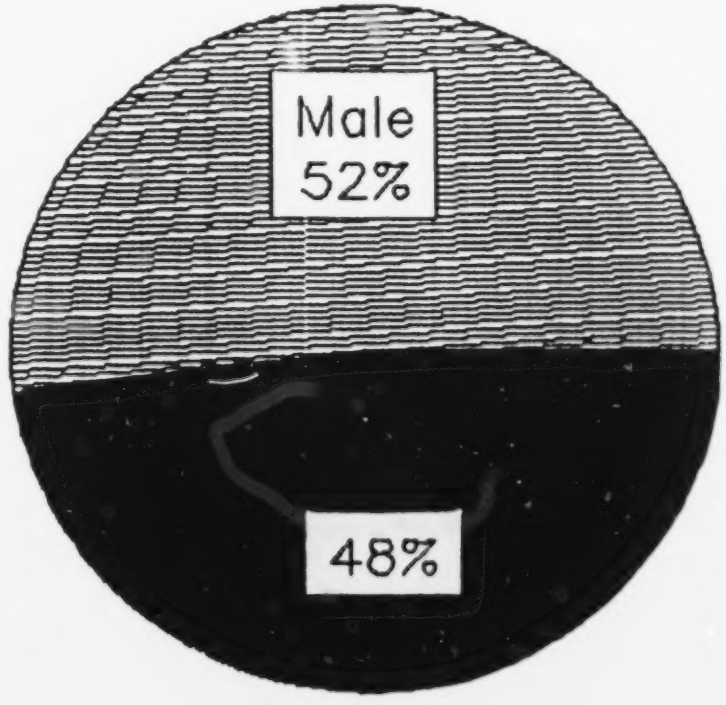


Figure 2
Racial Distribution of PRYDE Children
(N = 149)

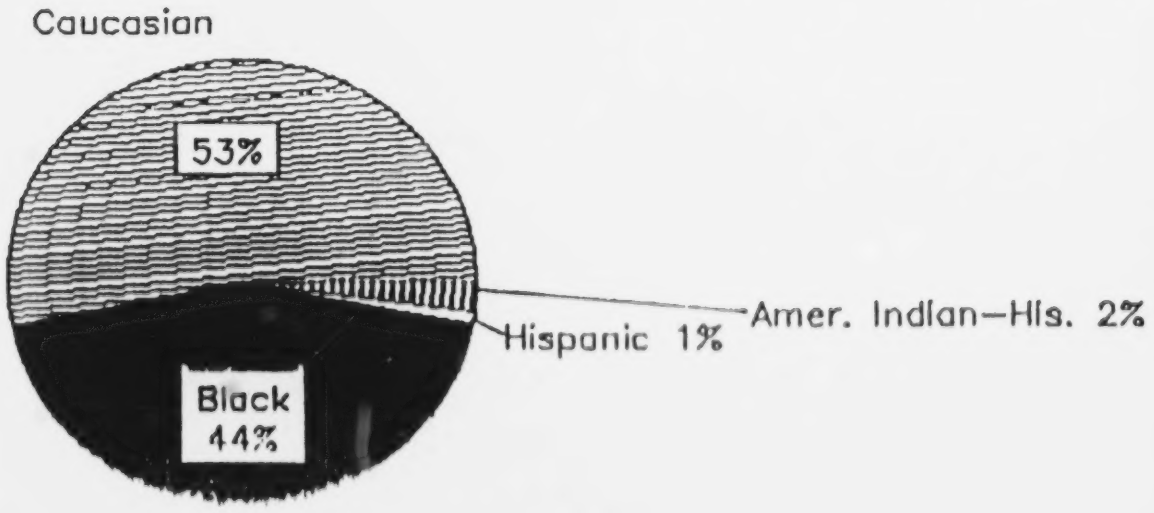


Figure 3
Mean Age and Range of Referred Children's First Out-of-Home Placement and Entry Into PRYDE (N = 133)

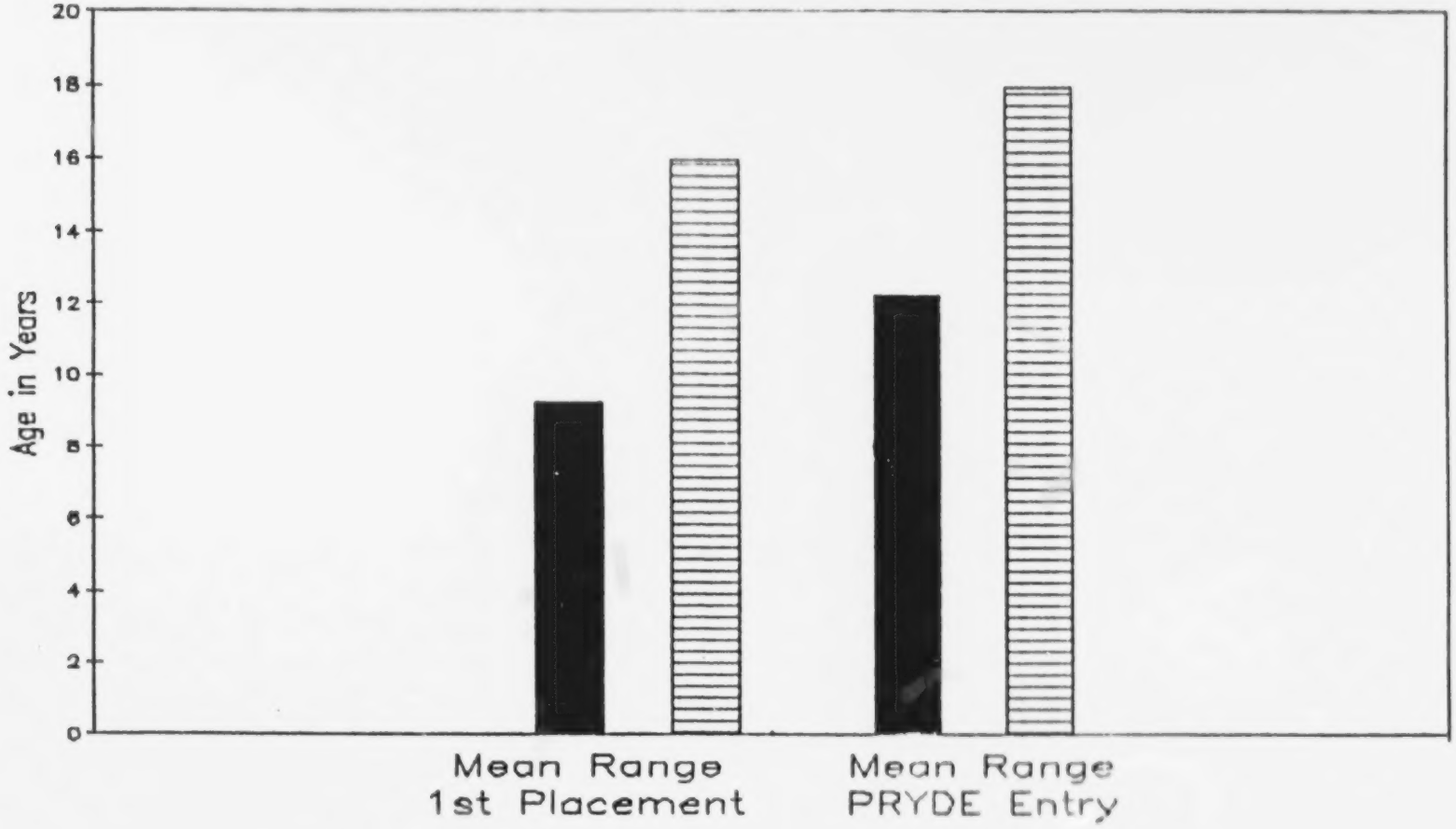


Figure 4
Primary Educational Classification of Current PRYDE Children (N = 136)

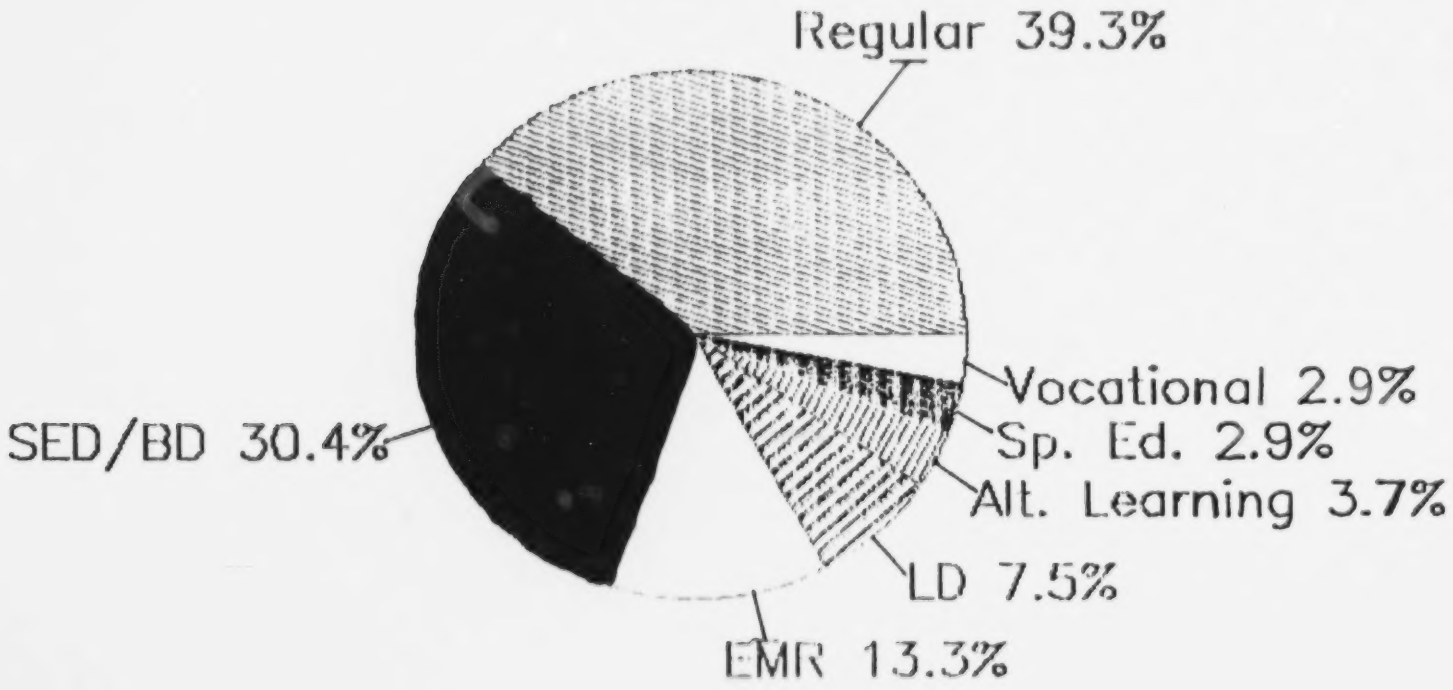
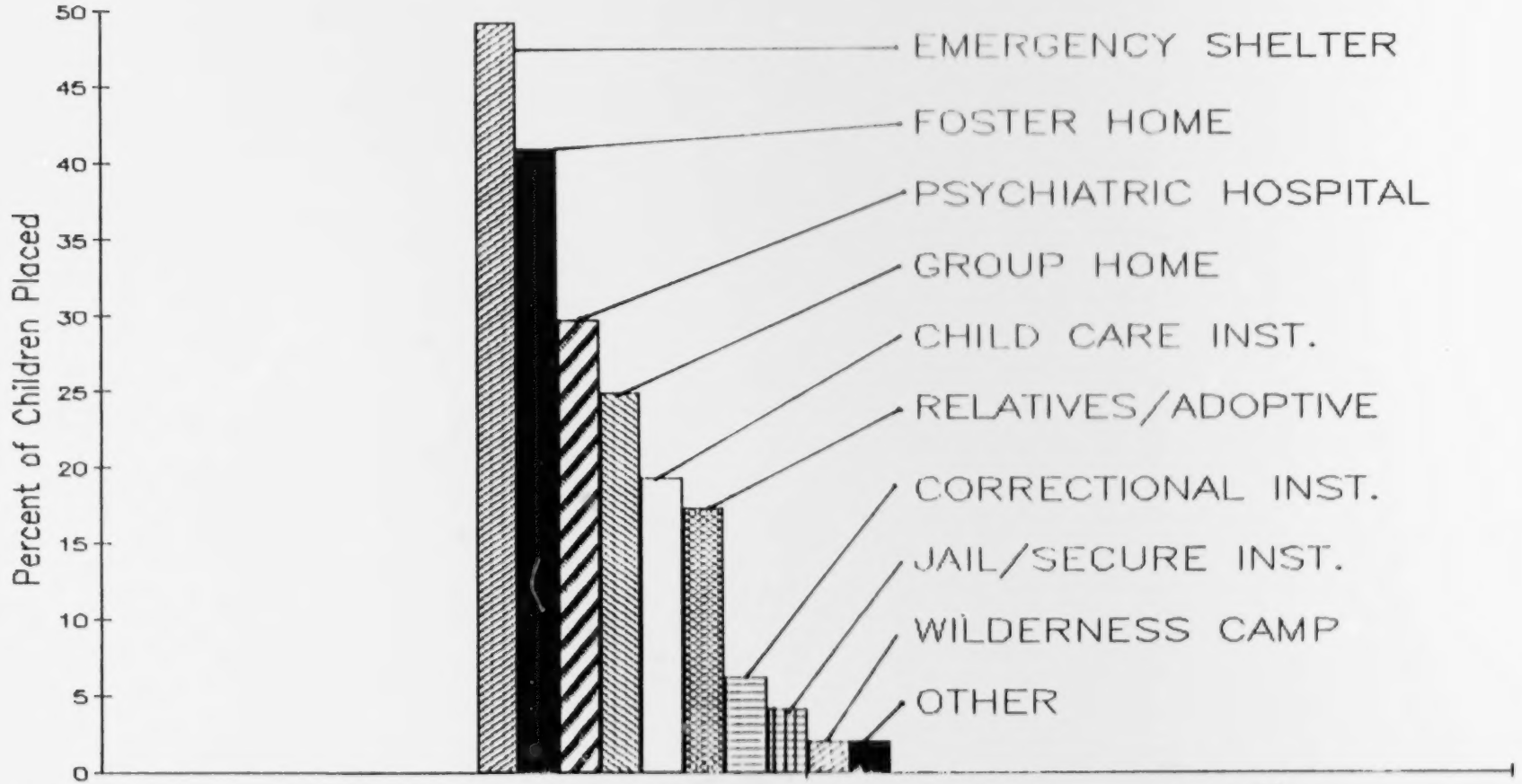


Figure 5
Relative Percents of Children's Prior Placements at Referral to PRYDE (N = 144)



Mean Prior Placements = 3.1 (R = 0-20)
NOTE: Percentages sum to more than 100

Figure 6
Relative Percentages of Child Problem Behaviors Reported at Referral (N=147)

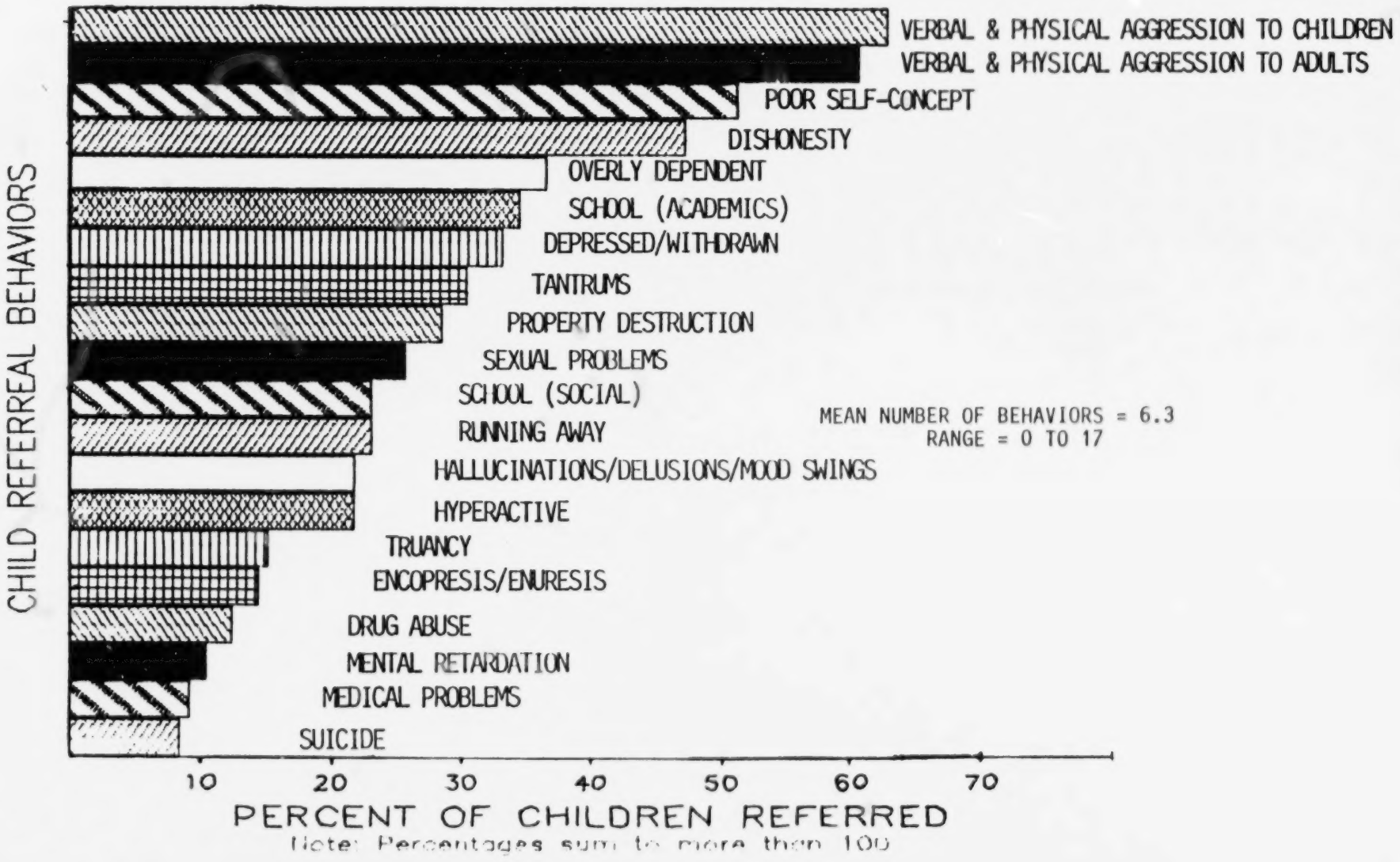


FIGURE 7

PRYDE MOTIVATION SYSTEM

NAME: _____

DAY: Monday

DATE: July 06, 1987

ALLOWANCE EARNED TODAY: 2.62

POINT SUMMARY FOR TODAY
PTS. EARNED: 550
PTS. LOST: 25
NET POINTS: 525

	BEHAVIOR	criterion for next move	current status	POSSIBLE PTS. +	POSSIBLE PTS. -	EARNED POINTS +	EARNED POINTS -
T_1	Emits a loud noise everytime W puts her hand(s) in her mouth while awake	14 consecutive days of no occurrences	(7)	75	75	75	
T_2	Place a preferred object within 12" of W and allow her to reach and grasp it during 10 trials	3 successful trials per day for 14 consecutive days		25	25	25	
T_3	Place a preferred object in W's hand(s) and note grasping and holding-10 trials	3 successful trials per day for 14 consecutive days		25	25	25	
T_4	Move object from side to side (160°) in front of W's face and note eye movement during 10 trials	3 successful trials per day for 14 consecutive days		25	25	—	—
T_5	Conduct physical therapy sessions for at least 30 minutes			100	100	100	
T_6	Place W on floor and measure distance she crawled after 10 minutes with prompting	3 feet/10 minutes		50	50	50	
T_7	Verbally present monosyllabic sounds to W and ask her to repeat each one during 10 trials per syllable	6 or more correct responses in 10 trials	UP TO 5	10 per syllable	10 per syllable	50	
T_8	Hold and present cup of fluid to W's mouth and note amount consumed and occurrence of choking during 7 trials	4 successful trials per training session for 14 consec. days		25	25	25	
T_9	Present preferred solid food (non-pureed) to W's mouth during 7 trials and note chewing, swallowing, and choking	4 successful trials per training session for 14 consec. days		25	25	25	
M_1	Place leg braces on W for at least minutes in AM and at least minutes in PM	8:45		25-AM 25-PM	25-AM 25-PM	25 25	
M_2	Brush W's teeth after each meal		UP TO 3	25	25	" 50	25
SED$_1$	Provide W with at least 30 min. of shared access to TV and/or music with family member(s)	Music		25	25	25	
I_1	Provide social outting (non-medical) with family member(s)	trip to Rancho		50		50	
I_2	Engage in planned ignoring procedure when W cries during the night			50		NA	no crying last night 25
			TOTAL THIS PAGE			550	

TO CALCULATE ALLOWANCE: $\frac{\text{Total \# of earned points}}{200}$ = dollar amount

DAILY MONITORING RECORD

AY: Monday

ATE: July 7, 1987

NOTE--If an item listed below was not conducted, enter "NA".

FIGURE 8

arget Behavior	FREQUENCY AM to Noon	12 to 6 PM	6 PM to Bed
and in mouth occurrences	2	4	1
eached & grasped an object	4/10 (K)	NA	NA
rasped & held an object	8/10 (K)	3/10	NA
oved eyes/head following an object	—	—	—
ength of physical therapy sessions	30 min. (K)	NA	10 Min
istance crawled after 10 minutes	NA	5ft/10 Min	5ft/30 Min
epeated a syllable (how many were used?)	A-G-B-E-D A repeated (K)	NA	NA
rank from cup when presented	2oz water (K) ¼ dripped	3oz. orange drink 1oz came out	CAN of Ensure Pickle dr.
ccurrences of choking following cup-drinking	0	None	1
uration of time that braces were worn	3	3½ hours	NA
rushed teeth	1	—	1

COMMENTS & OBSERVATIONS:

Wendy was very good today, cried very little. Wendy Ate about ½ of A can of Ham and Potatoes. She drank a little bit of orange drink (about 2oz). Wendy sat in her wheelchair and watch the children about ½ hour. Later we went to the hospital to visit someone. She was so good. We went to my parent's house, while I mowed the yard she sat on the patio and watch me, my dad kept playing with her feet, she giggled and just enjoyed it. We came home she ate her supper the other ½ of Ham + Potatoes. She laid on the floor and rolled. Put Wendy to bed Around 10 p.m.

A Very Good DAY for Wendy

Figure 9

Daily Average Per Week of Finger Mouthing and Biting Under Loud Noise Procedure